BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2012-378
STEPHEN THOMAS-KENT CHICK **450 Entrada Drive, Apt. 21** **Novato, CA 94949** **Registered Nurse License No. 720612** Respondent.	**DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about December 20, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2012-378 against Stephen Thomas-Kent Chick (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about February 19, 2008, the Board of Registered Nursing (Board) issued Registered Nurse License No. 720612 to Respondent. The Registered Nurse License expired on November 30, 2011, and has not been renewed.

3. On or about December 20, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2012-378, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of

Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board. Respondent's address of record was and is:

450 Entrada Drive, Apt. 21
Novato, CA 94949.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about January 25, 2012, the aforementioned certified mail documents were returned by the U.S. Postal Service marked "Unclaimed." The First Class mail documents were not returned.

6. Business and Professions Code section 2764 states:

> The lapsing or suspension of a license by a licentiate shall not deprive the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such a license.

7. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 2012-378.

9. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the

relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2012-378, finds that the charges and allegations in Accusation No. 2012-378, are separately and severally, found to be true and correct by clear and convincing evidence.

11. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $6,887.00 as of April 3, 2012.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Stephen Thomas-Kent Chick has subjected his Registered Nurse License No. 720612 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in Accusation Case No. 2012-378 which are supported by the evidence contained in the Default Decision Evidence Packet in this case.:

a. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, in that while on duty as a registered nurse on the Neuroscience Floor (9 West) at Community Regional Medical Center, Fresno, California, Respondent obtained the controlled substances Dilaudid and lorazepam by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In or about February 2009, Respondent removed various doses of Dilaudid and lorazepam from the medical center's PYXIS system (a computerized medication dispensing system; hereinafter "PYXIS") for patients A through F, and H through Q when, in fact, there were no physicians' orders authorizing the medications for the patients. Further, Respondent failed to chart the administration of the controlled substances on the patients' Medication Administration Records ("MAR") and 24-Hour Patient Care Record ("care record") or document the wastage of the controlled substances in the

PYXIS. In addition, Respondent removed Dilaudid from the PYXIS for patients B, I, and L after the patients had been discharged from the medical center.

b. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about February 2009, while on duty as a registered nurse on the Neuroscience Floor (9 West) at Community Regional Medical Center, Fresno, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Dilaudid, lorazepam, morphine, and Percocet, as set forth in Accusation Case No. 2012-378.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 720612, heretofore issued to Respondent Stephen Thomas-Kent Chick, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 27, 2012.

It is so ORDERED June 28, 2012

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

default decision_LIC.rtf
DOJ Matter ID:SA2011102077

Attachment:
Exhibit A: Accusation Case no. 2012-378

Exhibit A

Accusation

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEPHEN THOMAS-KENT CHICK** **450 Entrada Drive, Apt. 21** **Novato, CA 94949** **Registered Nurse License No. 720612** Respondent.	Case No. 2012-378 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about February 19, 2008, the Board issued Registered Nurse License Number 720612 ("license") to Stephen Thomas-Kent Chick ("Respondent"). Respondent's license was placed on inactive status. Respondent's license expired on November 30, 2011, and has not been renewed.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

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license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES

9. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J).

10. "Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16).

11. "Morphine/Morphine Sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

12. "Percocet", a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, in that while on duty as a registered nurse on the Neuroscience Floor (9 West) at Community Regional Medical Center, Fresno, California, Respondent obtained the controlled substances Dilaudid and Lorazepam by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In or about February 2009, Respondent removed various doses of Dilaudid and Lorazepam from the medical center's PYXIS system (a computerized medication dispensing system; hereinafter "PYXIS") for patients A through F, and H through Q when, in fact, there were no physicians' orders authorizing the medications for the patients. Further, Respondent failed to chart the administration of the controlled substances on the patients' Medication Administration Records ("MAR") and 24-Hour Patient Care Record ("care record") or document the wastage of the controlled substances in the PYXIS. In addition, Respondent removed Dilaudid from the PYXIS for patients B, I, and L after the patients had been discharged from the medical center.

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SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about February 2009, while on duty as a registered nurse on the Neuroscience Floor (9 West) at Community Regional Medical Center, Fresno, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Dilaudid, Lorazepam, Morphine, and Percocet, as follows:

Patient A

a. On February 7, 2009, at 0856 hours, Respondent removed Dilaudid 6 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 6 mg.

b. On February 7, 2009, at 1531 hours, Respondent removed Lorazepam 2 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Lorazepam on the patient's MAR and care record, document the wastage of the Lorazepam in the PYXIS, and otherwise account for the disposition of the Lorazepam 2 mg.

Patient B

c. On February 7, 2009, at 0732 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg. In addition, the patient's physician wrote an order at 0715 hours discharging the patient from the medical center.

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Patient C

d. On February 7, 2009, at 1301 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

e. On February 7, 2009, at 1727 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

f. On February 8, 2009, at 0720 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

g. On February 8, 2009, at 1140 hours, Respondent removed Dilaudid 6 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 6 mg.

h. On February 8, 2009, at 1646 hours, Respondent removed Dilaudid 6 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 6 mg.

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Patient D

i. On February 8, 2009, at 0856 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

j. On February 8, 2009, at 1810 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient E

k. On February 11, 2009, at 0734 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient F

l. On February 11, 2009, at 0818 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient H

m. On February 3, 2009, at 1652 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

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MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

n. On February 3, 2009, at 1853 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient I

o. On February 3, 2009, at 1246 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg. In addition, the patient's physician wrote an order on February 3, 2009, at 1100 hours discharging the patient from the medical center.

Patient J

p. On February 3, 2009, at 0843 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

q. On February 3, 2009, at 0800 hours, Respondent charted on the patient's care record that he administered Morphine to the patient, but failed to document the administration of the Morphine on the patient's MAR and/or otherwise account for the disposition of the Morphine.

Patient K

r. On February 3, 2009, at 0729 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

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MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient L

s. On February 4, 2009, at 0739 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

t. On February 3, 2009, the patient's physician issued an order for Morphine Sulfate 4 mg to be given to the patient intravenously every 3 hours as needed for severe pain. On February 4, 2009, registered nurse L.K. charted on the patient's MAR that she administered Morphine Sulfate 4 mg to the patient at 0700 hours. At 0800 hours, Respondent charted on the patient's care record that he administered Morphine to the patient "per MD order", when, in fact, the next scheduled dose of Morphine was not to be given to the patient until *1000 hours*. Further, Respondent inconsistently documented on the patient's MAR that he administered the Morphine to the patient at *1230* hours, and failed to indicate the dosage given to the patient.

u. On February 4, 2009, Respondent charted on the patient's care record that he administered Percocet to the patient at 0800 hours when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Percocet on the patient's MAR.

v. On February 4, 2009, at 1200 hours, Respondent documented on the patient's care record that he spoke with C. C. regarding changing the patient's medication order from Morphine to Dilaudid per the patient's request, and that the request was denied. At 1838 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg. In

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addition, the patient's physician wrote an order at 1720 hours discharging the patient from the medical center.

Patient M

w. On February 11, 2009, at 1058 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg. Further, Respondent documented on the patient's care record at 0800 and 1000 hours that the patient was receiving Morphine via a PCA (patient controlled analgesia) pump.

x. On February 11, 2009, at 1257 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

y. On February 11, 2009, at 1621 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

z. On February 11, 2009, at 1829 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

aa. On February 12, 2009, at 1159 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

bb. On February 12, 2009, at 1408 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

cc. On February 12, 2009, at 1452 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient N

dd. On February 12, 2009, at 0732 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient O

ee. On February 13, 2009, at 0737 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

ff. On February 13, 2009, at 0936 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

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MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient P

gg. On February 13, 2009, at 0820 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

hh. On February 13, 2009, at 1203 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

ii. On February 16, 2009, at 0805 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient Q

jj. On February 13, 2009, at 1435 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

kk. On February 13, 2009, at 1629 hours, Respondent removed Dilaudid 4 mg from the PYXIS for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

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MAR and care record, document the wastage of the Dilaudid in the PYXIS, and otherwise account for the disposition of the Dilaudid 4 mg.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 720612, issued to Stephen Thomas-Kent Chick;

2. Ordering Stephen Thomas-Kent Chick to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 20, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2011102077